S. No. 2
M—2-43
5-17-39
I X35697

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40908

FILED DEC 22 1943

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 5016

1. PLACE OF DEATH:
(a) County: JACKSON
(b) City or town: KANSAS CITY (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 210 Westport Road (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ In this community: 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 3309 Harrison (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) ✓
If yes, name country _____

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3. (a) PRINT FULL NAME: ROPPER-HAMERH.
3. (b) If veteran, name war: NO
3. (c) Social Security No.: none
4. Sex: Male
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: DIVORCED
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: JAN 8, 1889 (Month) (Day) (Year)
8. AGE: Years 54 Months 10 Days 19 If less than one day _____ hr. _____ min.
9. Birthplace: Maysville Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation: Carpenter
11. Industry or business: for self
MOTHER FATHER
12. Name: unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Alice Emmitt
(b) Address: 1401 Wood Kcks
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-30-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill
18. (a) Signature of funeral director: SODDARTH
(b) Address: KCMO
19. (a) 11-29-43 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 27 year 43 hour 8:00 P M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw h alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary sclerosis
Chronic interstitial nephritis

Due to: _____

Due to: 93d

Other conditions (Include pregnancy within 3 months of death): _____

Major findings:
Of operations: _____
Of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): _____
(b) Date of occurrence: _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury: _____
23. Signature: O. A. Bell M.D. Cor (Title of signer)
Address: _____ Date signed: 12-3-43

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(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.